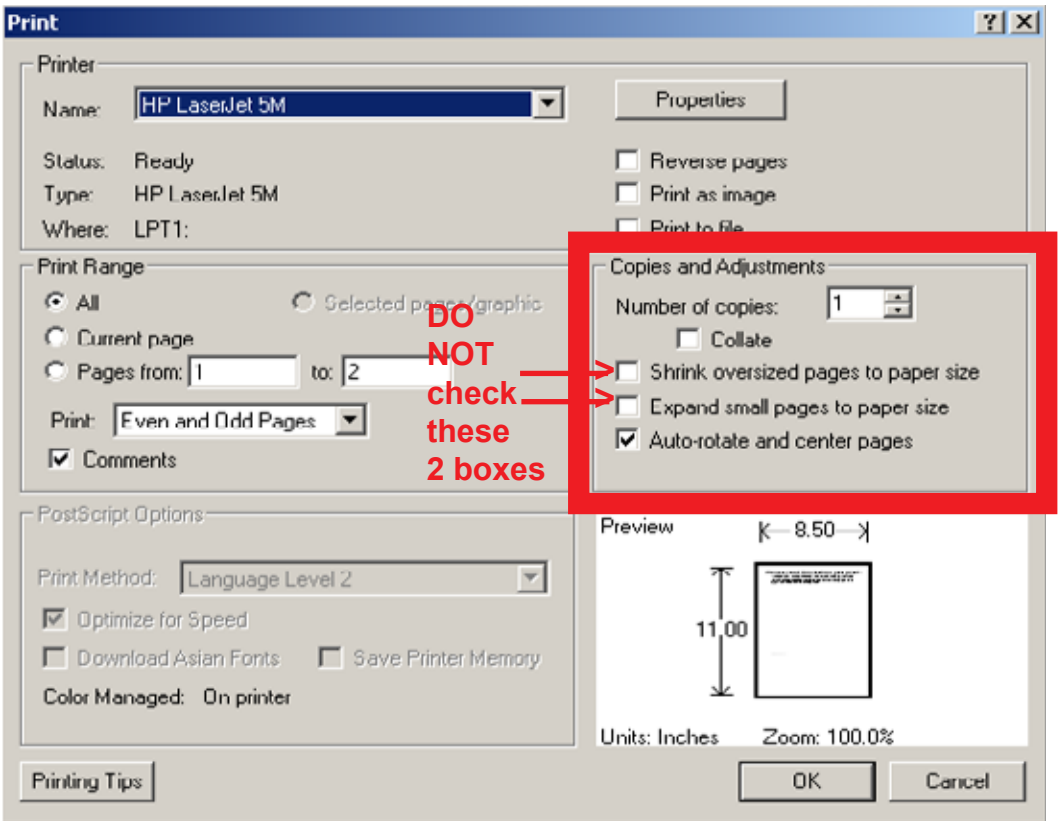
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



DOH 600-033 (7/2006)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Expired Nursing Assistant Registered (NAR) Activation Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Nursing Assistant Registered
(Expired)

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check No.** _____
☐ **Money Order**

DOH 667-035 (7/2006)

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Instructions For Expired Nursing Assistant Registered (NAR) Activation

It is important that the application is completed in full, either typed or clearly printed. This will avoid any delay in the registration process. The turnaround time from the date you mail the application to the time you receive your license is approximately six (6) weeks.

Attach the appropriate fee with this application.

Your NAR is expired from one (1) to three (3) years: $70

This total fee consists of the following fees:

$20.00 renewal fee
25.00 late renewal fee
25.00 reissuance fee

Section 1: Demographic Information:

Type or print clearly you name, street address and telephone number. If your address changes at any time after you have filed your application, it is your responsibility to notify the Department of Health. See WAC 246-12-310.

Indicate whether you are known or have been known under any other names. If you have a name change, it is your responsibility to notify the Department of Health in writing along with acceptable documentation. See WAC 246-12-300.

Indicate your social security number. Your application cannot be processed without this identifying information. It is required under Federal and state statute (42 USC 666 and Chapter 26.23 RCW).

Complete the remaining identifying information.

Section 2: AIDS Education and Training Attestation. Required by WAC 246-12-040.

Section 3: Criminal and Disciplinary Action Attestation. Required by WAC 246-12-040. This section pertains to formal or informal disciplinary action by any regulatory authorities, hospitals, state or federal jurisdictions, criminal convictions, and civil judgements connected with the practice of medicine. If you are unable to attest that you have not had action, please provide a synopsis of the situation, as well as the appropriate supporting documentation. **The Department does criminal background checks on all applicants.**

Section 4: Applicant's Attestation. Required to be signed and dated in order to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

Make the fee payable to the Department of Health.

Fees must accompany the application and are non-refundable.

Applications and fees are to be sent to: Department of Health
Nursing Assistant Program
P.O. Box 1099
Olympia, WA 98507-1099

All other inquiries and documents should be directed to: Department of Health
Nursing Assistant Program
P.O. Box 47864
Olympia, WA 98504-7864
(360) 236-4700

HIV/AIDS Information—AIDS Education Requirements For Health Related Professions

All health related professions under the disciplinary authority of the Uniform Disciplinary Act (RCW 18.130) are affected. This requirement went into effect January, 1989.

The topics that must be covered by this requirement are: *etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality and psychosocial issues to include special population considerations.* The course must be seven (7) hours or more in length.

If you completed your nursing program in 1989 or later and completed this requirement in the nursing courses, or a CE course, etc., after this time, you may complete the attestation portion of your application which specifies you have met this requirement. Keep documentation of completion for future reference. You may need to show proof to an employer.

If you feel you have not met this requirement, or you cannot document that you have, you can meet this requirement through a correspondence course or a community college. A partial listing of available offerings follows:

Robert D. Anderson Publishing Company
1-800-532-2332

Washington State University
Intercollegiate College of Nursing
1-800-281-2589

University of Washington
(206)543-1047

Impact Inc.
(206) 284-3865

Department of Health
AIDS Information Hot Line
1-800-272-2437
Website: http://www.doh.wa.gov/cfh/hiv_aids/prev_edu/training.htm

New York State Nurses Association
(518) 782-9400
E-mail: info@nysna.org
Website: http://www.nysna.org

Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FEE DATA (ALL FEES ARE NON-REFUNDABLE)	
☐ Late Renewal Penalty Fee	$
☐ Current Renewal Fee	$
☐ Substance Abuse Monitoring	$ N/A
☐ Expired Credential Reissuance Fee	$

CREDENTIAL #

Application For Expired Nursing Assistant Registered Activation

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.
All applications must be accompanied by the applicable fee, which is **non-refundable**.

1. Demographic Information

APPLICANT'S NAME LAST	FIRST	MIDDLE INITIAL

RESIDENTIAL ADDRESS		EMAIL ADDRESS	
CITY	STATE	ZIP	COUNTY

NOTE: Your registration document will show this address and all correspondence from the Department will be sent to this address until you notify us of a change.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	RESIDENTIAL TELEPHONE NUMBER	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)

Birthdate (Month/Day/Year) **(REQUIRED)**	PLACE OF BIRTH (CITY/STATE)	GENDER ☐ Female ☐ Male

Have you ever been known under any other name? ☐ Yes ☐ No

If yes, other name(s):

2. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS, either through my professional education or through the completion of DSHS required training for caregivers or staff employed in DDD Certified Residential Programs, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification or registration may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS

3. Criminal and Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

The Department does criminal background checks on all applicants.

APPLICANT'S INITIALS

4. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____ _____
SIGNATURE OF APPLICANT DATE

Official Use Only

Washington State Records Center